FINANCIAL STATEMENT FOR CONSIDERATION OF FINANCIAL ASSISTANCE

Attached is the Confidential Financial Statement to help determine eligibility. Please fill out to the best of your ability and return by_______________________________ .

If you have any questions please feel free to contact your personal Financial Counselor at:
If the first letter of your last name begins with:

A - L	Brooke	714-4401
M - Z	Heather	714-4400

Please attach the following documents:

- A brief written explanation of your circumstances
- Tax return for prior year, with copies of W2's. If self-employed we need 2 years of tax returns and current year to date profit and loss statements.
- Detailed bank statements for the last three months for all accounts
- Most recent check stub (showing year to date earnings) for all household members
- If applicable, benefit statement from Public Assistance (SSDI, PA, WIC, Food Stamps, etc.)
- A Medicaid Denial Letter from the Division of Public Assistance (DPA) is initially required for all patients who:
  - Are under the age of 18, or over the age of 65
  - Are, or were, pregnant at the time of service
  - Are part of a family with children living in the household under the age of 18
  - Had services rendered for a catastrophic illness/injury

  To get information about applying for Medicaid you can contact DPA at 283-2900

  For all other patients, a Denial Letter from DPA will not initially be required, but it may be requested after review of the Financial Assistance Application. The patient would then be required to provide the denial before the Financial Assistance approval/denial can be determined.

DEFINITIONS:

HOUSEHOLD A household consists of all persons who occupy a housing unit (house or apartment), whether they are related to each other or not. If a family and an unrelated individual, or two unrelated individuals, are living in the same housing unit, they would constitute two family units, but only one household.

INCOME Income includes total annual cash receipts before taxes from money wages and salaries before any deductions, net receipts from self-employment, regular payments from social security, railroad retirement, unemployment compensation, strike benefits from union funds, worker's compensation, veteran payments, public assistance (AFDC, TANF, etc), training stipends, alimony, child support, scholarships, grants, fellowships, dividends, interest, rental income, royalties, periodic receipts from estates or trusts, and net gambling or lottery winnings.

ASSETS Includes homes/buildings, land, vehicles, boats, recreational vehicles, as well as all bank accounts, retirement savings accounts, stocks, bonds, mutual funds, and any other valuable assets.

CPH is a member of the Planetree Alliance.

250 Hospital Place, Soldotna, AK 99669 ~ (907) 714-4404 * www.cpgh.org

CONFIDENTIAL FINANCIAL STATEMENT

Account #

Name		Adult Household Member #2 Name	Adult #2 Social Security #
Address		Adult #2 Employer	
City/State/Zip		Adult #2 Employer Address	
Telephone (Home)	Social Security #	City/State/Zip	Adult #2 Employer Phone #
Employer		Number of dependent Children / Ages	
Employer Address		Nearest Relative Not Living with you	
City/State/Zip		Relative's Relationship	
Employer Telephone		Relative's Telephone	

ASSETS		LIABILITIES		
Description	Current market Value	Description	Current Balance	Mo. Payment Amt.
Home (assessed value)		Home Mortgage / Rent		
Other Real Estate		Other Real Estate		
Vehicle Yr_____ Make		Vehicle Payments		
Vehicle Yr_____ Make		Credit Accounts:		
Boat Yr_____ Make		1.		
Checking: Average Balance		2.		
Savings & Certificates		3.		
Stocks, Bonds, Investments		4.		
Other Assets (Describe)		Medical Bills: (If over $5,000 attach copies)		
1.		1.		
2.		2.		
TOTAL		3.		

GROSS MONTHLY INCOME		OTHER MONTHLY EXPENSES	
SOURCES	AMOUNT	DESCRIPTION	AMOUNT
Salary (self)		Insurance (car, home, life, etc.)	
Salary (adult #2)		Medical insurance	
Social Security income (self)		Utilities	
Social Security income (adult #2)		Food	
Pension Income		Transportation	
Other Income (child support,, rental, etc.)		Daycare	
Food Stamps (provide proof)		Prescription Costs	
TOTAL		TOTAL	

I AGREE THAT ALL INSURANCE PAYMENTS RECEIVED FOR CENTRAL PENINSULA HOSPITAL SERVICES WILL BE APPLIED TO MY ACCOUNT AND THAT THE ANSWERS TO THE STATEMENTS ABOVE ARE TRUE AND FACTUAL TO THE BEST OF MY KNOWLEDGE. I FURTHER UNDERSTAND AND AGREE THAT THE INFORMATION HEREIN PROVIDED IS SUBJECT TO VERIFICATION WITH THIRD PARTIES AND OUTSIDE SOURCES.

DATE ______________________________ SIGNED ____

OFFICE USE ONLY	CFO/PFS DIRECTOR:	DATE:	ALL RESOURCES UTILIZED Y or N	Fin. Assist/Charity Care Y or N